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23 IN THE UNITED STATES DISTRICT COURT
24 DISTRICT OF NEVADA

25 UNITED STATES OF AMERICA *ex rel.*
26 CECILIA GUARDIOLA and

27 *Plaintiffs,*

28 Case No. 3:12-cv-00295-LRH-VPC

v.

29 RENOWN HEALTH,
30 RENOWN REGIONAL MEDICAL CENTER,
31 and RENOWN SOUTH MEADOWS
32 MEDICAL CENTER,

33 **SECOND AMENDED COMPLAINT**

34 *Defendants.*

35 **JURY DEMANDED**

36 On behalf of the United States of America, plaintiff and relator Cecilia Guardiola files

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1 this second amended *qui tam* complaint against defendants Renown Health, Renown Regional
 2 Medical Center, and Renown South Meadows Medical Center (collectively, “Renown” or the
 3 “Renown Health defendants”) to recover damages resulting from the defendants’ knowing efforts
 4 to defraud government-funded health insurance programs by improperly billing short-stay,
 5 outpatient services that should have been reimbursed on an outpatient basis as if they were more
 6 expensive inpatient services. In many situations, defendants billed the services as inpatient even
 7 though the patient was admitted to and discharged from the hospital on the same calendar day.
 8 As a result of their conduct, the defendants reaped substantial and illicit profits at taxpayer
 9 expense. Ms. Guardiola alleges:

11 **JURISDICTION AND VENUE**

12 1. The Court has jurisdiction over the subject matter of this action pursuant to both
 13 28 U.S.C. § 1331 and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on
 14 this Court for actions brought pursuant to 31 U.S.C. § 3730.

16 2. The Court has personal jurisdiction over defendants pursuant to 31 U.S.C. §
 17 3732(a) because the FCA authorizes nationwide service of process and defendants have sufficient
 18 minimum contacts with the United States.

19 3. Venue is proper in this district pursuant to 31 U.S.C. § 3732(a) because the
 20 defendants can be found, reside or have transacted business in the District of Nevada.

22 4. Substantially the same allegations or transactions as alleged in this action have not
 23 been publicly disclosed in a Federal criminal, civil, or administrative hearing in which the
 24 Government or its agent is a party; in a congressional, Government Accountability Office, or
 25 other Federal report, hearing, audit, or investigation; or from the news media.

26 5. To the extent that there has been a public disclosure unknown to the relator, the
 27 relator is an original source under 31 U.S.C. § 3730(e)(4). Relator is an individual who (1) prior
 28

1 to any public disclosure voluntarily disclosed to the Government the information on which
2 allegations or transactions in a claim are based, and/or (2) who has knowledge that is independent
3 of and materially adds to the publicly disclosed allegations or transactions, and who has
4 voluntarily provided the information to the Government before filing this action.
5

6 INTRODUCTION

7 6. This is an action to recover damages and civil penalties on behalf of the United
8 States of America arising from false or fraudulent claims and statements made or caused to be
9 made by the defendants to the United States in violation of the False Claims Act (“FCA”), 31
10 U.S.C. §§ 3729, *et seq.* The false or fraudulent claims, statements and records at issue involve
11 payments made by government-funded health insurance programs, such as Medicare, for services
12 provided by the defendants.
13

14 7. In general, the FCA provides that any person who knowingly submits or causes to
15 submit to the Government a false or fraudulent claim for payment or approval is liable for a civil
16 penalty of between \$5,500 and \$11,000 for each such claim, plus three times the amount of
17 damages sustained by the Government. The Act empowers private persons having information
18 regarding a false or fraudulent claim against the Government to bring an action on behalf of the
19 Government and to share in the recovery. The complaint must be filed under seal without service
20 on any defendant. The complaint remains under seal while the Government conducts an
21 investigation of the allegations in the complaint and determines whether to join the action.
22

23 8. Pursuant to the FCA, relator seeks to recover on behalf of the United States
24 damages and civil penalties arising from false and fraudulent claims, supported by false
25 statements, that defendants submitted or caused to be submitted to government-funded health
26 insurance programs.
27
28

PARTIES

9. Relator Cecilia Guardiola is a registered nurse, compliance professional and law school graduate with extensive nursing and compliance experience. On June 1, 2009, Ms. Guardiola was hired by the defendants as Director of Clinical Documentation. Her role was to improve the medical documentation in each patient's record to support improved billing. As Ms. Guardiola's responsibilities increased, she was promoted to Director of Clinical Compliance. She resigned her position with the defendants on January 15, 2012.

10. Ms. Guardiola brings this action for violations of the FCA on behalf of herself and the United States pursuant to 31 U.S.C. § 3730(b)(1).

11. Defendant Renown Health, a Nevada nonprofit corporation, is the umbrella organization under which related entities provide health care services through three acute care hospitals, a children's hospital, and a number of other health care facilities in Nevada. Renown Health was established in 2006 as the rebranded successor to Washoe Health System. Washoe Health System was founded as a private, non-profit corporation in 1984 when Washoe County transferred Washoe Medical Center (formerly Washoe County Hospital) to the newly-created entity. For fiscal year 2011, Renown Health reported 34,782 inpatient admissions and 101,707 ER visits at its two primary hospitals.

12. Defendant Renown Regional Medical Center (“Regional”) is a Nevada non-profit corporation located in Reno, Nevada and, upon information and belief, is a wholly-owned subsidiary of defendant Renown Health. Regional is a 558-bed acute care hospital that generated close to \$1.7 billion in total patient revenue during fiscal year 2011. The hospital treats a significant Medicare and Medicaid population and admits almost 8,500 Medicare inpatients annually.

13. Defendant Renown South Meadows Medical Center is a Nevada non-profit

1 corporation located in Reno, Nevada and, upon information and belief, is a wholly-owned
 2 subsidiary of defendant Renown Health. It is a 138-bed acute care hospital that generated over
 3 \$280 million in total patient revenue during 2011. The hospital treats a significant Medicare and
 4 Medicaid population and admits almost 1,800 Medicare inpatients annually.
 5

6 BACKGROUND ALLEGATIONS

7 Government-funded Health Insurance Programs

8 14. The defendants' wrongdoing was committed against government-funded health
 9 insurance programs, including, without limitation, Medicare.

10 15. Medicare is a federally-funded health insurance program primarily benefiting the
 11 elderly. It was created in 1965 when Title XVIII of the Social Security Act was adopted.
 12 Medicare is administered by and through Centers for Medicare & Medicaid Services ("CMS").
 13

14 Inpatient and Outpatient Status Defined

15 16. During relevant time periods, Medicare defined an inpatient as a "person who has
 16 been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital
 17 services." *Medicare Benefit Policy Manual*, Ch. 1, § 10 (Pub. 100-02). The patient's physician is
 18 "responsible for deciding whether the patient should be admitted as an inpatient." *Id.* Physicians
 19 may order inpatient "admission for patients who are expected to need hospital care for 24 hours
 20 or more, and treat others on an outpatient basis." *Id.*
 21

22 17. CMS recognizes that "the decision to admit is a complex medical judgment"
 23 requiring a physician to consider various factors such as "[t]he severity of the signs and
 24 symptoms exhibited by the patient" and "[t]he medical predictability of something adverse
 25 happening to the patient." *Id.* Significantly, CMS notes that "[a]dmissions of particular patients
 26 are not covered or noncovered solely on the basis of the length of time the patient actually spends
 27 in the hospital." *Id.* In particular, "[w]hen patients with known diagnoses enter a hospital for a
 28

1 specific minor surgical procedure or other treatment" that is expected to keep a patient in the
2 hospital for less than 24 hours, the patient must be considered an outpatient for Medicare
3 coverage purposes. *Id.*

4 18. Bridging the gap between inpatient and outpatient admission status is "outpatient
5 observation" status. "Observation care is a well-defined set of specific, clinically appropriate
6 services, which include ongoing short term treatment, assessment, and reassessment before a
7 decision can be made regarding whether patients will require further treatment as hospital
8 inpatients or if they are able to be discharged from the hospital." *Medicare Benefit Policy*
9 *Manual*, Ch. 6, § 20.6.B. (Pub. 100-02).

10 19. Outpatient observation is a specific hospital admission status that may be
11 appropriate under a variety of circumstances. It is "commonly assigned to patients . . . who
12 require a significant period of treatment or monitoring before a decision is made concerning their
13 admission or discharge." *Id.* at § 20.5.A.; *see Medicare Claims Processing Manual*, Ch. 4, §
14 290.1 (Rev. 1, 10-03-03). Outpatient observation also is appropriate when the physician requires
15 additional time to evaluate the patient before deciding whether the patient needs inpatient
16 admission, the physician anticipates that the patient's condition can be evaluated or treated within
17 24 hours or rapid improvement in the patient's condition is anticipated within 24 hours.
18 Observation status is commonly assigned to patients who present to the emergency department
19 and require a period of treatment or monitoring before a decision is made concerning their
20 admission or discharge. *Medicare Benefit Policy Manual*, Pub. at § 20.5.A. Observation status is
21 also often appropriate for outpatient surgical patients whose condition requires extra recovery or
22 follow up care. *Id.*

23 **Coding of Patient Claims**

24 20. Outpatient procedures are classified and reported using Medicare's Healthcare
25

1 Common Procedure Coding System (“HCPCS”). This system is based primarily on *Current*
2 *Procedural Terminology* (“CPT”), published by the American Medical Association. The CPT
3 uses five-digit codes with descriptive terms to identify services performed by health care
4 providers and is the country’s most widely-accepted coding reference.
5

6 21. Outpatient services provided under HCPCS codes are classified into ambulatory
7 payment classifications (APCs) on the basis of clinical and cost similarity. All services within an
8 APC have the same payment rate. Within each APC, CMS packages certain related services and
9 items with the primary service.

10 22. Inpatient procedures are billed using a different system. For hospitals, there are
11 several types of charges that are incorporated into the hospital bill, including facility and ancillary
12 charges. Hospital facility charges consist of room, board and nursing care. Ancillary charges
13 include radiology, laboratory, pharmacy and miscellaneous supplies. The facility and ancillary
14 charges are coded using the ICD-9-CM system for inpatient hospital care for diagnoses and
15 procedures.
16

17 23. Inpatient hospital stays are also coded using a three-digit Medicare severity
18 diagnosis-related group (MS-DRG). The MS-DRG system was developed for Medicare as part of
19 the inpatient prospective payment system. It is used to classify hospital cases into one of
20 approximately 500 groups based on the expectation that the cases use similar hospital resources.
21 The MS-DRG charge is dependent upon the level of care that the patient requires, with higher
22 intensity of care being reflected with a higher charge. The patient’s level of care is, in part,
23 determined by the procedures performed while in the hospital. Such procedures are coded using a
24 4-digit number in the form xx.xx based on the International Classification of Diseases, Ninth
25 Revision, Clinical Modification (“ICD-9-CM”) system, established by CMS and the National
26 Center for Health Statistics. The MS-DRG payment is intended to be a single, all-encompassing
27
28

1 payment covering all facility and ancillary charges, regardless of how long the patient is admitted
 2 or the number of services provided.

3 **Evaluating Appropriate Patient Status**

4 24. When evaluating a patient's admission status, hospitals overwhelmingly rely on
 5 guidance known as InterQual Criteria. InterQual is an industry-standard suite of products
 6 designed by McKesson Corporation that allows healthcare organizations to achieve a clinically
 7 validated approach to decision-making on patient care, patient status and billing issues. The
 8 InterQual Criteria are used to objectively measure the severity of the illness (SI) and the intensity
 9 of the service (IS) provided to arrive at a determination of the appropriate service level.

10 25. Of critical importance in determining patient status is Medicare's "Inpatient Only
 11 List," which identifies those specific surgical procedures that are only paid on an inpatient basis.
 12 While procedures not included on the inpatient-only list are not precluded from being performed
 13 on an inpatient basis, inpatient billing is only appropriate when justified by the patient's medical
 14 needs. Many of the claims alleged to have been improperly billed by the defendants as inpatient
 15 are for procedures not on the Inpatient Only List and for which no other criteria justified inpatient
 16 admission.

17 **Services Must be "Medically Necessary" and Fully Documented**

18 26. CMS requires, as a condition of coverage, that services be reasonable and
 19 medically necessary. 42 U.S.C. § 1395y(a)(1)(A). Providers must provide economical medical
 20 services and, then, provide such services only where medically necessary. 42 U.S.C. §
 21 1320c-5(a)(1). Providers must provide evidence that the service is medically necessary and
 22 appropriate, 42 U.S.C. § 1320c-5(a)(3), and must ensure that services provided are not
 23 substantially in excess of patient needs, 42 U.S.C. § 1320a-7(b)(6), (8).

24 27. Federal law specifically prohibits providers from making "any false statement or

1 representation of a material fact in any application for any . . . payment under a Federal health
 2 care program.” *See* 42 U.S.C. § 1320a-7b(a)(1). Similarly, Federal law requires providers who
 3 discover material omissions or errors in claims submitted to Medicare to disclose those omissions
 4 or errors to the Government. *See* 42 U.S.C. § 1320a-7b(a)(3). The requirement that providers be
 5 truthful in submitting claims for reimbursement is a precondition for participation in the Medicare
 6 program. *See, e.g.*, 42 C.F.R. §§ 1003.105, 1003.102(a)(1)-(2).

8 28. In order to establish eligibility to receive reimbursement from the Medicare
 9 program, CMS requires all hospitals to sign a Certification Statement as part of the Medicare
 10 Provider Agreement (CMS-855A Enrollment Application), which states in pertinent part,

11 I agree to abide by the Medicare laws, regulations and program instructions that
 12 apply to this provider. The Medicare laws, regulations, and program instructions
 13 are available through the Medicare contractor. I understand that payment of a
 14 claim by Medicare is conditioned upon the claim and the underlying transaction
 15 complying with such laws, regulations, and program instructions (including, but
 16 not limited to, the Federal anti-kickback statute and the Stark law), and on the
 17 provider's compliance with all applicable conditions of participation in Medicare.
 18 * * *

19 I will not knowingly present or cause to be presented a false or fraudulent claim
 20 for payment by Medicare, and I will not submit claims with deliberate ignorance
 21 or reckless disregard of their truth or falsity.

22 *Medicare Provider Agreement*, Sec. 15 (Certification Statement) at ¶¶ 4, 6 (CMS-855A
 23 Enrollment Application (07-11)).

24 29. In order to establish eligibility to receive reimbursement from the Medicare
 25 program, CMS requires all physicians to sign a Certification Statement as part of the Medicare
 26 Provider Agreement (CMS-855I Enrollment Application), which states in pertinent part,

27 I agree to abide by the Medicare laws, regulations and program instructions that
 28 apply to me or to the organization listed in Section 4A of this application. The
 29 Medicare laws, regulations, and program instructions are available through the
 30 fee-for-service contractor. I understand that payment of a claim by Medicare is
 31 conditioned upon the claim and the underlying transaction complying with such
 32 laws, regulations, and program instructions (including, but not limited to, the
 33 Federal anti-kickback statute and the Stark law), and on the supplier's compliance

1 with all applicable conditions of participation in Medicare.
2 * * * * *
3

4 I will not knowingly present or cause to be presented a false or fraudulent claim
5 for payment by Medicare, and will not submit claims with deliberate ignorance or
6 reckless disregard of their truth or falsity.
7

8 *Medicare Provider Agreement*, Sec. 15 (Certification Statement) at ¶¶ 4, 8 (CMS-855I
9 Enrollment Application (07-11)).
10

11 30. Defendants, as participants in the Medicare program, signed and submitted to
12 CMS the Medicare Provider Agreement (CMS-855A) and required that their physicians sign and
13 submit the CMS Medicare Provider Agreement for Physicians (CMS-855I), containing the
14 language cited in paragraphs 28-29 herein, and indicating their agreement to be bound by the laws
15 and regulations governing Medicare reimbursement for services.
16

17 31. Medicare requires providers to submit claims on paper or electronically using
18 universal billing formats. Regardless of the format used, a provider's obligations to Medicare
19 remain the same.
20

21 32. Beginning in 2007, paper claim submissions have been made using Medicare's
22 UB-04 Uniform Bill (CMS 1450). The UB-04 (CMS-1450) notifies the provider, such as
23 defendants, as follows:
24

25 THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESEN-
26 TATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS RE-
27 QUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL
28 MONE-TARY PENALTIES AND ASSESSMENTS AND MAY UPON CON-
29 VICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL
30 AND/OR STATE LAW(S).
31

32 The form also requires entities submitting a claim to certify:
33

34 Submission of this claim constitutes certification that the billing information as
35 shown on the face hereof is true, accurate and complete. That the submitter did
36 not knowingly or recklessly disregard or misrepresent or conceal material facts...
37

38 33. To submit claims electronically, which most providers, including defendants, are
39

1 required to do, a provider must enroll in Medicare's Electronic Data Interchange (EDI) program.
2 The enrollment process provides for the collection of the information needed to successfully
3 exchange EDI transactions with Medicare and establishes the expectations of the parties to the
4 exchange. The unique EDI number issued to a provider, along with its password, acts as the
5 provider's electronic signature for claim submission.
6

7 34. As part of the EDI enrollment process, a provider is required to certify, among
8 other things, that "it will submit claims that are accurate, complete, and truthful," that "it will
9 acknowledge that all claims will be paid from Federal funds, that the submission of such claims is
10 a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies
11 or causes to be misrepresented or falsified any record or other information relating to that claim
12 that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or
13 imprisonment under applicable Federal law," and that "it will research and correct claim
14 discrepancies." To complete its EDI enrollment, a provider representative must "certify that I
15 have been appointed an authorized individual to whom the provider has granted the legal
16 authority to enroll it in the Medicare Program . . . and to commit the provider to abide by the
17 laws, regulations and the program instructions of Medicare." *See Medicare Claims Processing*
18 *Manual, Ch. 24, § 30.2.* Upon information and belief, Ms. Guardiola alleges that defendants made
19 these or similar certifications.
20

21 35. Once an institutional provider, such as the defendants, has been enrolled in the EDI
22 program, the provider submits Medicare claims electronically using CMS Form 837I. The
23 electronic billing specifications and data elements prescribed by CMS for CMS-837I are
24 consistent with the data elements present on the CMS UB-04 (CMS-1450) paper claim form. In
25 fact, Renown personnel usually refer to Medicare claim billing documentation as the "UB,"
26 regardless of the method by which a claim was submitted to Medicare.
27

36. Defendants, as participants in the Medicare program, submitted their bills for services to Medicare using the UB-04 (CMS-1450), CMS-837I, or their equivalents, containing the language cited in paragraphs 28, 32, or 34 herein, or similar language, and indicating their agreement to be bound by the laws and regulations governing Medicare reimbursement for services, including but not limited to certification of compliance with 42 U.S.C. § 1395y(a)(1)(A).

37. Pursuant to the Medicare Provider Agreements, EDI Enrollment Agreements, UB-04 (CMS-1450), CMS-837I and/or similar documents, by submitting claims for Medicare reimbursement, defendants certified to CMS that those claims are for services provided in compliance with CMS and federal laws and regulations.

38. Federal law specifically obligates every provider to return to the United States any payment that it improperly receives. It is a felony for an entity to conceal or fail to disclose errors in payments received from government-funded health insurance programs. 42 U.S.C. § 1320a-7b(a)(3).

SPECIFIC ALLEGATIONS

39. When Ms. Guardiola first arrived at Renown, she conferred with colleagues and conducted a non-scientific review of patient charts to determine the quality of clinical documentation. She quickly discovered that clinical documentation at Renown was subpar and that the institution possessed a culture that did not emphasize compliance. The problems at Renown cause the defendants to violate the FCA by submitting short-stay inpatient claims (“zero day stays” and “one-day stays”) that should be billed on an outpatient basis. Renown’s deliberate and knowing failure and refusal to maintain proper documentation and its deliberate intent to promote and foster a culture of non-compliance was intended to and did cause the defendants to falsely and intentionally misrepresent and submit short-stay inpatient claims (“zero day stays”

1 and “one-day stays”) that should be billed on an outpatient basis.

2 **Renown Routinely Submitted Fraudulent Inpatient Claims**

3 40. The defendants systematically submitted to the government claims for short-term
 4 inpatient treatment that should have been properly categorized as outpatient because of (1)
 5 inadequate clinical documentation to support claims submitted; (2) antiquated computer systems
 6 that generated false claims; (3) processes designed to improperly assign patient admission status;
 7 and (4) a lack of required utilization review to ensure appropriate patient status. By virtue of the
 8 foregoing, Renown submitted claims that it knew were false or were submitted in reckless
 9 disregard of the truth.

10 41. Ms. Guardiola alleges that a high percentage of patient files at Regional and South
 11 Meadows were missing physician orders for inpatient status and/or contained inadequate
 12 documentation of the patient’s severity of illness. Renown knew or, in reckless disregard of the
 13 truth, should have known that the documentation was missing and inadequate but submitted the
 14 claims anyway. Renown knew or should have known that the claims were false or submitted in
 15 reckless disregard of the truth.

16 42. Renown used an aging patient management system designed by Siemens. When
 17 entered into the Siemens system, a patient who is initially and improperly registered as an
 18 inpatient remained in that status until discharge because the status of an “active” patient cannot be
 19 changed. Even if the patient is treated on an outpatient or outpatient observation basis and
 20 properly coded as such, the Siemens system overrides such accurate coding and sequences the
 21 billing codes according to the original patient status, resulting in an incorrect inpatient billing.
 22 This problem affects both medical and surgical procedures at Regional and South Meadows.
 23 Notwithstanding its knowledge of such problems, Renown submitted claims that it knew were
 24 false or, in reckless disregard of the truth, should have known were false.

1 43. Ms. Guardiola first detected the problem with the Siemens system during the
 2 fourth quarter of 2009. Renown administrators are well aware of the problem and did nothing to
 3 prevent it.

4 44. Because Renown intended to install a new billing system, called EPIC, in March
 5 2012, it was unwilling to expend any resources to correct the problems arising from the Siemens
 6 system, opting to continue lining its own pockets at the government's expense.

7 45. The EPIC system is expected to improve Renown's billing capabilities but it will
 8 not solve the problems alleged here. In addition, the new system will create other problems. For
 9 instance, the new system allows physicians to sign all pending orders without reviewing them
 10 individually or having any direct interaction with them. Because Renown is now permitting such
 11 "rubber stamping," the EPIC system will exacerbate the existing problems of inadequate
 12 physician orders failing to document patient status.

13 **Processing of Patients for Elective Surgical Procedures**

14 46. While the inflexible Siemens system presents challenges, its problems could be
 15 overcome by appropriate patient admissions processes. For years, Renown failed to implement
 16 any procedures to prevent the improper admissions generated by the Siemens system and, in fact,
 17 maintained procedures that amplified the shortcomings of the Siemens system. By virtue of
 18 maintaining such procedures, Renown knew or, in reckless disregard of the truth, should have
 19 known that claims it was submitting were false.

20 47. When a patient is scheduled for a procedure, her doctor's office calls the hospital
 21 scheduler and sets up a surgical appointment. This is a ministerial, clerical activity — a simple
 22 reservation — that allows the hospital to schedule necessary operating room time and arrange
 23 needed equipment.

24 48. Once the appointment is scheduled, hospital personnel assign a patient account

1 number that is unique for that encounter. Account numbers preceded by a '1' designate inpatient
 2 status. Numbers that start with a '2' specify outpatient treatment. Account numbers beginning
 3 with a '3' reflect patients entering the hospital through the Emergency Room (ER) and are not
 4 used by the advance schedulers.

5 49. Unless the doctor's office specifically tells the hospital that the patient should be
 6 listed as a "same day surgery" or specifically says that the procedure will be done on an
 7 outpatient basis, Renown automatically assigns an inpatient account number. When the patient
 8 arrives at Renown, the patient's actual treatment is irrelevant to the Medicare billing because the
 9 patient account number has predetermined how the Siemens system will bill Medicare.

10 50. Typically, from three to seven days before the scheduled procedure, the patient's
 11 physician issues a preoperative order that provides specific orders, requests labs, and designates
 12 the patient's admission status. Renown does not use this information to change or correct the
 13 status already associated with the patient account number.

14 51. After the patient is discharged, the medical records are presented to a medical
 15 coder who assigns procedure and ICD-9 codes appropriate to the treatment provided. Assuming
 16 the patient was treated on an outpatient or outpatient observation basis, the coder will correctly
 17 use outpatient CPT and APC codes to bill the claim. Renown does not use this information to
 18 change or correct the status already associated with the patient account number.

19 52. At that point, Renown's Siemens system takes over. Because of the inpatient
 20 account number that was pre-assigned during the reservation process, the Siemens system detects
 21 an inconsistency between the numeric patient status and assigned billing codes, recognizes that
 22 the MS-DRG inpatient billing code is missing and automatically generates an MS-DRG.

23 53. Renown — through the Siemens system — ignores the coder's work and
 24 appropriate outpatient status and automatically bills the claim as if inpatient status was correct.

1 By virtue of such acts and conduct, Renown knows or, in reckless disregard of the truth, should
 2 have known that the claims it was submitting were false.

3 54. Despite understanding the problems created, Renown was unwilling to correct the
 4 problem by providing staff to perform appropriate pre-admission review. Until late 2011, Ms.
 5 Guardiola's repeated requests to have a trained pre-access nurse hired to oversee the admissions
 6 intake process were denied, primarily due to the opposition of the Case Management Department.

7 **Post-Procedure Review Lacking**

8 55. In addition to the pre-admission procedural and computer problems, post-
 9 procedure orders continue to cause improper Medicare billing at Renown. For instance, even if
 10 an incorrect inpatient status is corrected by a pre-access review, Renown still has significant
 11 problems with post-procedure orders that do not meet inpatient criteria. Due to the lack of an
 12 effective utilization review plan or any type of post-procedure review, Renown continues to
 13 submit false claims to government-funded health insurance programs. Due to the lack of
 14 effective utilization review plan or any type of post-procedure review, Renown submitted claims
 15 that it knew were false or, in reckless disregard of the truth, should have known were false.

16 56. At the time of her hiring, Ms. Guardiola found that Renown performed no timely
 17 review to ensure correct patient status. Defendants did not have a Utilization Review Committee
 18 or any type of utilization review plan at any of their hospitals, a violation of Medicare's
 19 conditions of participation. A Utilization Review Committee would ordinarily provide real-time
 20 review after a patient admission had occurred to ensure that patient status is properly assigned
 21 before billing takes place. The defendants also did not and do not use any objective, third-party
 22 tools to conduct post-procedure utilization review and verify medical necessity determinations, all
 23 with the design, purpose and intent of submitting false claims.

24 57. At Ms. Guardiola's urging, a Utilization Review Committee was established, but it

1 met only four times. During Ms. Guardiola's time at Renown, the Committee did not meet after
 2 July 2010 and had been, effectively, disbanded.

3 58. Renown's Case Management Department is wholly inadequate. At Regional, the
 4 ineffective head of Case Management, Kelly Wilcher, resigned in or about March 2011 for her
 5 role in a HIPAA violation and the department has continued to be ineffective since that time. The
 6 then-interim head of Case Management, Kim Lewis, opposed Ms. Guardiola's efforts including
 7 her attempts to hire a pre-access nurse, but has since left Renown. Despite Ms. Guardiola's
 8 efforts, Case Management refused to review any claims that are less than 2 days in length. As a
 9 result, Renown failed to address the short stay problem that Ms. Guardiola identified and, by such
 10 failure, intended to and did continue to submit false claims.

12 **Renown's Senior Management is Well-Aware of and Directed the Wrongdoing**

13 59. Realizing the need to quantify her findings more specifically to gain support for
 14 the reforms she knew were needed, Ms. Guardiola in 2009 approached her then-boss, Renown
 15 Health CFO Mark Johnson, with her concerns that Renown was billing Medicare for one-day
 16 inpatient stays for what should have been outpatient claims. Johnson approved Ms. Guardiola's
 17 proposed formation of a Patient Status Committee (PSC) to explore the scope of the problem and
 18 recommend and implement corrections. In November 2009, CFO Johnson resigned from
 19 Renown.

20 60. Shortly after Johnson's departure, Ms. Guardiola provided Dawn Ahner, the new
 21 Renown Health CFO, with a patient status PowerPoint presentation. Ahner was concerned with
 22 Ms. Guardiola's report about the systemic misbilling of outpatient claims and inadequate Case
 23 Management function at Renown and agreed to proceed with the previously-approved PSC
 24 proposal.

25 61. The PSC operated under Ms. Guardiola's stewardship for the ensuing nine months.

1 The Committee brought together representatives of five hospital departments — Case
2 Management, Physicians, Patient Access/Registration, Audit and Nursing — with the goal of
3 ensuring the accuracy of patient status orders and billing. Each department acted as a
4 subcommittee of the PSC. The PSC met monthly, and the subcommittees met weekly.
5

6 62. One of the PSC's first initiatives was to address the findings of an audit of 282
7 randomly-selected and statistically significant Medicare claims to verify the accuracy and
8 completeness of clinical documentation. The audit revealed that Renown had a significant "one-
9 day stay" problem based on inaccurate clinical documentation. It demonstrated that Renown was
10 submitting inpatient claims for patients whose one-day hospital stays should have been billed on
11 an outpatient basis.
12

13 63. The PSC attempted to implement in early 2010 some corrections to Renown's
14 billing processes, but only for certain situations. First, nurse managers and case managers began
15 conducting a daily "census reconciliation" that sought to ensure that a patient's status matched an
16 actual physician order and case management was permitted to place a "bill hold" on problem
17 claims. Second, coders started reviewing every case for a physician status order and were
18 allowed to place a "hold" on claims that did not have an appropriate order.
19

20 64. The new safeguards did not correct the most significant problems at Renown,
21 because their implementation was inconsistent. The nurse managers and case managers did not
22 perform consistently the daily census reconciliation. High turnover among Renown coders made
23 the coder review process inconsistent. Even when it did work, coders were only looking for
24 situations when the physician's order was inconsistent with the patient's status. Renown was
25 aware that the new safeguards were not adequate, did nothing to correct the problems and, by
26 such awareness and failure, knew or should have known that it was continuing to submit false
27 claims.
28

1 65. In addition, Renown still refused to undertake any post-procedure reviews to
 2 ensure that a patient's status was determined immediately after a surgical procedure was
 3 completed and that the patient's status was correct. Such reviews, usually conducted by a nurse
 4 case manager, quickly determine whether a patient's care and condition are routine or whether
 5 complications arose which might require a status change. By such refusal, Renown knew or
 6 should have known that it was continuing to submit false claims.
 7

8 66. Ms. Guardiola and Sue Sutherland from Billing Compliance unsuccessfully raised
 9 concerns about the lack of an effective utilization review function numerous times with their
 10 superiors, particularly Renown Health CFO Dawn Ahner and all senior members of the patient
 11 status committee (CFO Mark Johnson, COO Kris Gaw, Director of Patient Financial Services
 12 Laurence Laughlin, VP of Utilization Karla Pambogo and Chief Medical Officer Max Jackson).
 13

14 Failed Educational Efforts and Other Factors Contributed to Renown's Problems

15 67. In connection with the PSC's efforts, Ms. Guardiola conducted extensive
 16 counseling sessions and educational efforts throughout the hospital to encourage greater
 17 compliance with admissions status standards. Written guidance was distributed repeatedly to
 18 physicians and staff. The status decisions being applied to patients undergoing scheduled surgical
 19 procedures continued to be a huge challenge because physicians and surgical departments refused
 20 to adopt the PSC's safeguards, including a failure to implement pre-access or post-procedure
 21 review.
 22

23 68. Ms. Guardiola conducted a series of meetings — as many as 20 in all — during the
 24 first half of 2010 to educate physicians and hospital personnel on the importance of selecting an
 25 accurate patient status and the factors that go into making the selection.

26 69. On December 17, 2010, Ms. Guardiola conducted a separate physician training
 27 program to provide education on the patient status issues and billing requirements for surgical
 28

1 procedures performed using the daVinci robotic system.

2 70. Renown, at Ms. Guardiola's recommendation, hired Executive Health Resources
3 (EHR), a medical management consulting firm, to work with physicians in a peer-to-peer setting
4 to educate them on appropriate patient status decisionmaking and perform patient status
5 utilization review for Medicare ER patients.

6 71. Despite these extensive efforts, Renown was unable or unwilling to address the
7 short stay problem. And by virtue of its unwillingness to rectify the problem, knew or, in reckless
8 disregard of the truth, should have known it was submitting false claims.

9 72. A counseling session held for the Admissions Department proved useless in
10 improving patient status accuracy because the department openly ignored the guidance provided.
11 The Admissions Department's inaction resulted from physicians who were demanding that their
12 patients be admitted on an inpatient basis, regardless of whether the patient's condition warranted
13 it.

14 73. Physicians were skeptical of the educational efforts and openly challenged the
15 guidance that certain diagnoses could not be billed as inpatient.

16 74. For instance, in March 2010, Business Development Administrator Joan Lapham
17 received from Dr. Michael Song "a list of frequently used CPT codes for neurosurgery and asked
18 that [she] verify which of them CMS classifies as inpatient vs. outpatient." Lapham responded
19 that "only two of the CPT codes . . . are on the Inpatient Only list; all of the others are outpatient
20 . . ." Dr. Song responded, "Are you sure? Most of these codes are inpatient codes I believe."

21 75. In January 2011, emails between hospital personnel and physicians' staff included
22 reports that "Renown and [Dr. Martin Naughton's] management team had a meeting and said that
23 all Da Vinci hysterectomy procedures need to be inpatient," even though such procedures are not
24 on the Medicare Inpatient Only List.

1 76. As late as May 2011, Ms. Guardiola had conversations with cardiologist Dr.
 2 Devang Desai who insisted that stenting procedures should be performed on an inpatient basis
 3 even though they are not on Medicare's Inpatient Only List.

4 77. Dr. Eric Drummer was counseled by Ms. Guardiola after she found that he was
 5 routinely performing outpatient cardiac stent insertions on an inpatient basis.

7 78. During her conversations with Drs. Drummer and Desai, Ms. Guardiola
 8 determined that they had been improperly billing for stents for a long time and got the impression
 9 that the improper billing would continue, despite her efforts.

10 79. Moreover, Renown's coding department was usually understaffed. Hospital
 11 management placed intense pressure on the coders to produce, especially at month's end.
 12 Regional and South Meadows usually employed three coders in-house and an additional 11 or 12
 13 coders on a contract basis, but the department's effectiveness is compromised by frequent
 14 personnel changes. Management's emphasis is always on productivity and reducing the backlog
 15 of uncoded claims, leaving little time to review suspect charts.

17 80. Coders routinely code claims that are missing required documentation. Coders
 18 focus on getting the diagnosis and DRG/CPT coding done in order to meet productivity
 19 requirements, which places little emphasis on accuracy. Renown's use of contract coders only
 20 exacerbates this situation, because the short-term needs of these non-employees are productivity-
 21 based, leaving them with little interest in serving the long-term goals of the institution. And by
 22 virtue of the acts and omissions set forth above, Renown knew or, in reckless disregard of the
 23 truth, should have known that it was continuing to submit false claims.

25 81. Renown's fraudulent conduct and its false billings preceded Ms. Guardiola's
 26 employment. During the course of Ms. Guardiola's review and audit of Medicare claims, she
 27 discovered false claims dating back to 2006, 2007 and 2008, some of which are set forth in
 28

1 paragraphs 85 and 88. In addition, Ms. Guardiola learned from colleagues that the aging and
2 inadequate Siemens system, which Renown knew was the source for some of the fraud alleged,
3 had been in operation for more than ten years. Because of the inherent and long-term problems
4 with the Siemens billing system, the systemic nature of defendants' fraudulent scheme, the lack
5 of utilization review or case management, and Renown's cultural resistance to correct the
6 fraudulent billing, defendants knowingly and routinely submitted the types of false claims alleged
7 here for many years prior to Ms. Guardiola's employment at Renown. As a result, Ms. Guardiola
8 alleges, upon information and belief, that defendants' wrongdoing occurred for up to ten years
9 prior to her employment.

10 82. Renown's fraudulent conduct and its false billings also continued after Ms.
11 Guardiola's employment. The cultural, systemic and integrated nature of the wrongdoing
12 described herein continued when Ms. Guardiola's employment ended. These practices persisted
13 after her departure because key personnel who opposed process and billing changes that would
14 have corrected the fraud remained in defendants' employ, physician groups responsible for
15 certain irregularities continued to practice at Renown, and Renown managers who resisted and
16 obstructed corrective actions and instructed physicians to bill improperly remained in their
17 positions long after Ms. Guardiola's departure. As a result, Ms. Guardiola alleges, upon
18 information and belief, that defendants' wrongdoing continued to occur even after her
19 employment ended.

20 83. Although Ms. Guardiola cannot identify every false claim that the defendants
21 submitted to government-funded health insurance programs, such information being in the
22 possession of the defendants, she alleges that the following claims are representative of the
23 defendants' fraudulent billing. For each claim, the procedures performed or treatment provided
24 were improperly billed to government-funded health insurance programs on a more expensive
25

1 inpatient basis and should have been billed on an outpatient or outpatient observation basis.

2 **Specific False Claims — Zero-Day Stays**

3 84. Ms. Guardiola alleges that defendants routinely submitted to Medicare false claims
4 for inpatient admissions lasting less than 24 hours (“Zero Day Stays”). Zero Day Stays may occur
5 when a patient is admitted to and discharged from the hospital on the same calendar day or may
6 involve an overnight stay that spans more than one calendar day.

7 85. The following claims are illustrative examples of both medical and surgical
8 treatments for which the patient was admitted to and discharged from the hospital on the same
9 calendar day. These Zero Day Stays include the following Medicare claims for which relator will,
10 under an appropriate protective order, provide additional patient information:

CLAIM	ADMITTED	DISCHARGED
1	2007/07/07	2007/07/07
2	2007/07/25	2007/07/25
3	2007/08/13	2007/08/13
4	2007/09/17	2007/09/17
5	2007/10/22	2007/10/22
6	2008/04/26	2008/04/26
7	2006/09/07	2006/09/07
8	2007/02/12	2007/02/12
9	2007/06/14	2007/06/14
10	2006/07/31	2006/07/31
11	2008/02/01	2008/02/01
12	2008/03/22	2008/03/22
13	2007/06/27	2007/06/27
14	2007/07/14	2007/07/14
15	2007/09/07	2007/09/07
16	2006/09/21	2006/09/21
17	2007/06/03	2007/06/03
18	2008/05/31	2008/05/31
19	2007/06/13	2007/06/13
20	2007/08/13	2007/08/13
21	2007/05/25	2007/05/25
22	2007/11/03	2007/11/03
23	2008/01/17	2008/01/17
24	2008/02/09	2008/02/09
25	2008/02/21	2008/02/21
26	2008/01/22	2008/01/22
27	2008/04/11	2008/04/11
28	2006/08/25	2006/08/25

CLAIM	ADMITTED	DISCHARGED
29	2006/10/10	2006/10/10
30	2006/10/19	2006/10/19
31	2007/01/27	2007/01/27
32	2007/06/15	2007/06/15
33	2006/12/05	2006/12/05
34	2008/05/03	2008/05/03
35	2008/05/06	2008/05/06
36	2007/12/31	2007/12/31
37	2007/06/06	2007/06/06
38	2007/05/22	2007/05/22
39	2007/05/20	2007/05/20
40	2008/05/30	2008/05/30
41	2008/01/07	2008/01/07
42	2008/05/04	2008/05/04
43	2007/05/01	2007/05/01
44	2006/08/10	2006/08/10
45	2006/11/22	2006/11/22
46	2007/01/29	2007/01/29
47	2007/09/20	2007/09/20
48	2007/10/11	2007/10/11
49	2007/12/07	2007/12/07
50	2007/12/12	2007/12/12
51	2007/12/19	2007/12/19
52	2008/03/02	2008/03/02
53	2006/08/17	2006/08/17
54	2006/10/10	2006/10/10
55	2006/12/17	2006/12/17
56	2007/03/28	2007/03/28
57	2007/06/29	2007/06/29
58	2007/07/14	2007/07/14
59	2007/02/22	2007/02/22
60	2007/09/25	2007/09/25
61	2008/05/20	2008/05/20
62	2006/09/05	2006/09/05
63	2007/01/01	2007/01/01
64	2007/01/14	2007/01/14
65	2007/01/20	2007/01/20
66	2007/04/08	2007/04/08
67	2007/05/16	2007/05/16
68	2007/06/26	2007/06/26
69	2007/09/29	2007/09/29
70	2007/10/23	2007/10/23
71	2008/04/14	2008/04/14
72	2006/07/29	2006/07/29
73	2007/02/07	2007/02/07
74	2007/04/24	2007/04/24
75	2007/06/04	2007/06/04
76	2007/06/11	2007/06/11
77	2007/06/22	2007/06/22
78	2007/07/17	2007/07/17

CLAIM	ADMITTED	DISCHARGED
79	2007/09/05	2007/09/05
80	2008/02/15	2008/02/15
81	2008/03/11	2008/03/11
82	2006/10/24	2006/10/24
83	2006/11/28	2006/11/28
84	2006/12/27	2006/12/27
85	2007/12/18	2007/12/18
86	2008/02/28	2008/02/28
87	2007/09/26	2007/09/26
88	2006/09/30	2006/09/30
89	2006/11/22	2006/11/22
90	2007/02/28	2007/02/28
91	2007/04/11	2007/04/11
92	2007/04/20	2007/04/20
93	2007/05/12	2007/05/12
94	2007/09/11	2007/09/11
95	2007/10/29	2007/10/29
96	2007/11/02	2007/11/02
97	2007/11/24	2007/11/24
98	2007/11/29	2007/11/29
99	2007/12/02	2007/12/02
100	2007/12/22	2007/12/22
101	2006/08/31	2006/08/31
102	2006/09/25	2006/09/25
103	2006/10/01	2006/10/01
104	2006/10/02	2006/10/02
105	2006/10/04	2006/10/04
106	2006/10/16	2006/10/16
107	2006/10/22	2006/10/22
108	2006/11/01	2006/11/01
109	2007/01/08	2007/01/08
110	2007/02/18	2007/02/18
111	2007/02/28	2007/02/28
112	2007/03/05	2007/03/05
113	2007/04/14	2007/04/14
114	2007/05/09	2007/05/09
115	2007/06/03	2007/06/03
116	2007/06/10	2007/06/10
117	2007/07/10	2007/07/10
118	2007/07/16	2007/07/16
119	2007/08/17	2007/08/17
120	2007/08/23	2007/08/23
121	2007/08/24	2007/08/24
122	2007/12/22	2007/12/22
123	2008/01/11	2008/01/11
124	2008/01/20	2008/01/20
125	2008/01/28	2008/01/28
126	2008/03/05	2008/03/05
127	2006/07/26	2006/07/26
128	2007/02/23	2007/02/23

CLAIM	ADMITTED	DISCHARGED
129	2007/08/05	2007/08/05
130	2008/03/27	2008/03/27
131	2008/04/30	2008/04/30
132	2008/03/01	2008/03/01
133	2008/02/08	2008/02/08
134	2007/12/29	2007/12/29
135	2006/09/06	2006/09/06
136	2008/02/13	2008/02/13
137	2007/12/28	2007/12/28
138	2006/12/17	2006/12/17
139	2007/01/12	2007/01/12
140	2007/08/05	2007/08/05
141	2006/08/01	2006/08/01
142	2006/12/26	2006/12/26
143	2007/06/23	2007/06/23
144	2007/12/28	2007/12/28
145	2008/01/22	2008/01/22
146	2006/07/01	2006/07/01
147	2006/08/29	2006/08/29
148	2006/11/10	2006/11/10
149	2006/11/28	2006/11/28
150	2006/12/01	2006/12/01
151	2007/07/22	2007/07/22
152	2007/11/18	2007/11/18
153	2008/02/10	2008/02/10
154	2008/02/24	2008/02/24
155	2007/08/08	2007/08/08
156	2007/04/16	2007/04/16
157	2007/12/06	2007/12/06
158	2007/08/11	2007/08/11
159	2007/08/06	2007/08/06
160	2007/08/14	2007/08/14
161	2008/05/22	2008/05/22
162	2008/05/07	2008/05/07
163	2006/09/20	2006/09/20
164	2007/05/01	2007/05/01
165	2007/08/04	2007/08/04
166	2006/12/04	2006/12/04
167	2007/08/07	2007/08/07
168	2007/02/14	2007/02/14
169	2007/05/10	2007/05/10
170	2007/10/10	2007/10/10
171	2008/05/05	2008/05/05
172	2007/07/28	2007/07/28
173	2006/11/10	2006/11/10
174	2006/11/19	2006/11/19
175	2006/08/18	2006/08/18
176	2007/04/25	2007/04/25
177	2007/09/25	2007/09/25
178	2007/11/21	2007/11/21

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CLAIM	ADMITTED	DISCHARGED
179	2007/11/22	2007/11/22
180	2008/01/05	2008/01/05
181	2008/03/28	2008/03/28
182	2008/04/21	2008/04/21
183	2007/07/12	2007/07/12
184	2006/11/10	2006/11/10
185	2007/05/09	2007/05/09
186	2007/05/19	2007/05/19
187	2007/08/16	2007/08/16
188	2008/02/24	2008/02/24
189	2006/10/01	2006/10/01
190	2006/10/03	2006/10/03
191	2006/08/01	2006/08/01
192	2006/09/08	2006/09/08
193	2006/07/16	2006/07/16
194	2007/11/07	2007/11/07
195	2007/11/19	2007/11/19
196	2008/05/25	2008/05/25
197	2006/12/02	2006/12/02
198	2006/11/11	2006/11/11
199	2006/12/06	2006/12/06
200	2006/07/04	2006/07/04
201	2006/07/10	2006/07/10
202	2007/04/17	2007/04/17
203	2007/05/22	2007/05/22
204	2008/01/09	2008/01/09
205	2008/03/13	2008/03/13
206	2006/07/15	2006/07/15
207	2006/12/21	2006/12/21
208	2007/01/28	2007/01/28
209	2007/03/16	2007/03/16
210	2007/05/31	2007/05/31
211	2007/08/14	2007/08/14
212	2007/11/26	2007/11/26
213	2006/08/09	2006/08/09
214	2008/05/09	2008/05/09
215	2006/10/03	2006/10/03
216	2007/06/03	2007/06/03
217	2008/03/11	2008/03/11
218	2007/06/02	2007/06/02
219	2007/07/04	2007/07/04
220	2008/04/29	2008/04/29
221	2008/05/15	2008/05/15
222	2006/08/25	2006/08/25
223	2006/11/26	2006/11/26
224	2006/12/09	2006/12/09
225	2008/01/14	2008/01/14
226	2007/01/15	2007/01/15
227	2007/11/28	2007/11/28
228	2008/04/08	2008/04/08

CLAIM	ADMITTED	DISCHARGED
229	2006/10/05	2006/10/05
230	2007/10/28	2007/10/28
231	2008/04/29	2008/04/29
232	2007/12/09	2007/12/09
233	2007/04/27	2007/04/27
234	2007/04/24	2007/04/24
235	2006/10/03	2006/10/03
236	2007/01/22	2007/01/22
237	2008/01/19	2008/01/19
238	2008/03/16	2008/03/16
239	2007/12/23	2007/12/23
240	2006/09/22	2006/09/22
241	2006/11/04	2006/11/04
242	2006/12/10	2006/12/10
243	2006/12/12	2006/12/12
244	2007/01/13	2007/01/13
245	2007/02/28	2007/02/28
246	2007/07/13	2007/07/13
247	2007/08/13	2007/08/13
248	2007/12/22	2007/12/22
249	2007/12/21	2007/12/21
250	2007/11/21	2007/11/21
251	2007/12/29	2007/12/29
252	2007/04/19	2007/04/19
253	2007/06/08	2007/06/08
254	2008/02/23	2008/02/23
255	2008/03/22	2008/03/22
256	2006/08/19	2006/08/19
257	2007/08/13	2007/08/13
258	2007/12/05	2007/12/05
259	2007/01/23	2007/01/23
260	2007/07/06	2007/07/06
261	2007/11/10	2007/11/10
262	2008/05/26	2008/05/26
263	2007/11/01	2007/11/01
264	7/8/2010	7/8/2010
265	8/31/2010	8/31/2010
266	9/9/2010	9/9/2010
267	9/12/2010	9/12/2010
268	9/30/2010	9/30/2010
269	1/15/2011	1/15/2011
270	12/10/2010	12/10/2010
271	10/29/2010	10/29/2010
272	11/16/2010	11/16/2010
273	1/19/2011	1/19/2011
274	8/8/2010	8/8/2010
275	9/12/2010	9/12/2010
276	3/13/2011	3/13/2011
277	9/20/2010	9/20/2010
278	10/14/2010	10/14/2010

1	CLAIM	ADMITTED	DISCHARGED
2	279	9/19/2010	9/19/2010
3	280	3/11/2011	3/11/2011
4	281	3/24/2011	3/24/2011
5	282	7/4/2010	7/4/2010
6	283	8/17/2010	8/17/2010
7	284	8/30/2010	8/30/2010
8	285	12/11/2010	12/11/2010
9	286	1/15/2011	1/15/2011
10	287	2/8/2011	2/8/2011
11	288	3/22/2011	3/22/2011
12	289	9/21/2010	9/21/2010
13	290	10/10/2010	10/10/2010
14	291	11/27/2010	11/27/2010
15	292	8/27/2010	8/27/2010
16	293	2/28/2011	2/28/2011
17	294	3/28/2011	3/28/2011
18	295	7/23/2010	7/23/2010
19	296	8/9/2010	8/9/2010
20	297	10/28/2010	10/28/2010
21	298	1/5/2011	1/5/2011
22	299	3/15/2011	3/15/2011
23	300	11/28/2010	11/28/2010
24	301	10/1/2010	10/1/2010
25	302	10/22/2010	10/22/2010
26	303	11/19/2010	11/19/2010
27	304	7/10/2010	7/10/2010
28	305	9/4/2010	9/4/2010
29	306	11/27/2010	11/27/2010
30	307	2/2/2011	2/2/2011
31	308	7/23/2010	7/23/2010
32	309	9/6/2010	9/6/2010
33	310	10/12/2010	10/12/2010
34	311	10/6/2010	10/6/2010
35	312	11/24/2010	11/24/2010
36	313	7/22/2010	7/22/2010
37	314	8/10/2010	8/10/2010
38	315	8/10/2010	8/10/2010
39	316	11/14/2010	11/14/2010
40	317	12/8/2010	12/8/2010
41	318	7/6/2010	7/6/2010
42	319	8/7/2010	8/7/2010
43	320	9/23/2010	9/23/2010
44	321	10/9/2010	10/9/2010
45	322	10/10/2010	10/10/2010
46	323	10/26/2010	10/26/2010
47	324	11/3/2010	11/3/2010
48	325	2/5/2011	2/5/2011
49	326	7/11/2010	7/11/2010
50	327	7/23/2010	7/23/2010
51	328	8/1/2010	8/1/2010

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CLAIM	ADMITTED	DISCHARGED
329	8/22/2010	8/22/2010
330	9/5/2010	9/5/2010
331	9/18/2010	9/18/2010
332	10/18/2010	10/18/2010
333	11/25/2010	11/25/2010
334	11/28/2010	11/28/2010
335	12/30/2010	12/30/2010
336	2/4/2011	2/4/2011
337	2/12/2011	2/12/2011
338	3/10/2011	3/10/2011
339	3/14/2011	3/14/2011
340	2/14/2011	2/14/2011
341	2/16/2011	2/16/2011
342	2/23/2011	2/23/2011
343	12/1/2010	12/1/2010
344	3/8/2011	3/8/2011
345	9/8/2010	9/8/2010
346	7/7/2010	7/7/2010
347	1/14/2011	1/14/2011
348	7/2/2010	7/2/2010
349	7/8/2010	7/8/2010
350	7/22/2010	7/22/2010
351	7/23/2010	7/23/2010
352	7/26/2010	7/26/2010
353	7/30/2010	7/30/2010
354	8/4/2010	8/4/2010
355	8/18/2010	8/18/2010
356	9/5/2010	9/5/2010
357	11/27/2010	11/27/2010
358	1/26/2011	1/26/2011
359	1/31/2011	1/31/2011
360	7/26/2010	7/26/2010
361	10/27/2010	10/27/2010
362	10/8/2010	10/8/2010
363	11/14/2010	11/14/2010
364	11/23/2010	11/23/2010
365	10/1/2010	10/1/2010
366	11/12/2010	11/12/2010
367	12/3/2010	12/3/2010
368	10/5/2010	10/5/2010
369	11/30/2010	11/30/2010
370	7/15/2010	7/15/2010
371	3/23/2011	3/23/2011
372	11/10/2010	11/10/2010
373	9/18/2010	9/18/2010
374	11/14/2010	11/14/2010
375	12/29/2010	12/29/2010
376	12/30/2010	12/30/2010
377	1/10/2011	1/10/2011
378	1/28/2011	1/28/2011

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CLAIM	ADMITTED	DISCHARGED
379	11/30/2010	11/30/2010
380	1/3/2011	1/3/2011
381	1/18/2011	1/18/2011
382	7/8/2010	7/8/2010
383	9/3/2010	9/3/2010
384	1/10/2011	1/10/2011
385	1/16/2011	1/16/2011
386	10/28/2010	10/28/2010
387	2/16/2011	2/16/2011
388	7/28/2010	7/28/2010
389	3/3/2011	3/3/2011
390	9/8/2010	9/8/2010
391	12/18/2010	12/18/2010
392	9/17/2010	9/17/2010
393	8/31/2010	8/31/2010
394	9/7/2010	9/7/2010
395	12/20/2010	12/20/2010
396	12/26/2010	12/26/2010
397	1/15/2011	1/15/2011
398	2/6/2011	2/6/2011
399	3/2/2011	3/2/2011
400	8/13/2010	8/13/2010
401	9/19/2010	9/19/2010
402	9/2/2010	9/2/2010
403	7/28/2010	7/28/2010
404	3/6/2011	3/6/2011
405	7/22/2010	7/22/2010
406	8/8/2010	8/8/2010
407	8/29/2010	8/29/2010
408	12/12/2010	12/12/2010
409	7/28/2010	7/28/2010
410	8/17/2010	8/17/2010
411	9/3/2010	9/3/2010
412	11/8/2010	11/8/2010
413	1/12/2011	1/12/2011
414	1/31/2011	1/31/2011
415	2/22/2011	2/22/2011
416	8/9/2010	8/9/2010
417	9/10/2010	9/10/2010
418	2/1/2011	2/1/2011
419	3/11/2011	3/11/2011
420	8/9/2010	8/9/2010
421	8/31/2010	8/31/2010
422	7/8/2010	7/8/2010
423	8/31/2010	8/31/2010
424	9/9/2010	9/9/2010
425	9/12/2010	9/12/2010
426	9/30/2010	9/30/2010
427	1/15/2011	1/15/2011
428	12/10/2010	12/10/2010

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1	CLAIM	ADMITTED	DISCHARGED
2	429	10/29/2010	10/29/2010
3	430	11/16/2010	11/16/2010
4	431	1/19/2011	1/19/2011
5	432	8/8/2010	8/8/2010
6	433	9/12/2010	9/12/2010
7	434	3/13/2011	3/13/2011
8	435	9/20/2010	9/20/2010
9	436	10/14/2010	10/14/2010
10	437	9/19/2010	9/19/2010
11	438	3/11/2011	3/11/2011
12	439	3/24/2011	3/24/2011
13	440	7/4/2010	7/4/2010
14	441	8/17/2010	8/17/2010
15	442	8/30/2010	8/30/2010
16	443	12/11/2010	12/11/2010
17	444	1/15/2011	1/15/2011
18	445	2/8/2011	2/8/2011
19	446	3/22/2011	3/22/2011
20	447	9/21/2010	9/21/2010
21	448	10/10/2010	10/10/2010
22	449	11/27/2010	11/27/2010
23	450	8/27/2010	8/27/2010
24	451	2/28/2011	2/28/2011
25	452	3/28/2011	3/28/2011
26	453	7/23/2010	7/23/2010
27	454	8/9/2010	8/9/2010
28	455	10/28/2010	10/28/2010
29	456	1/5/2011	1/5/2011
30	457	3/15/2011	3/15/2011
31	458	11/28/2010	11/28/2010
32	459	10/1/2010	10/1/2010
33	460	10/22/2010	10/22/2010
34	461	11/19/2010	11/19/2010
35	462	7/10/2010	7/10/2010
36	463	9/4/2010	9/4/2010
37	464	11/27/2010	11/27/2010
38	465	2/2/2011	2/2/2011
39	466	7/23/2010	7/23/2010
40	467	9/6/2010	9/6/2010
41	468	10/12/2010	10/12/2010
42	469	10/6/2010	10/6/2010
43	470	11/24/2010	11/24/2010
44	471	7/22/2010	7/22/2010
45	472	8/10/2010	8/10/2010
46	473	8/10/2010	8/10/2010
47	474	11/14/2010	11/14/2010
48	475	12/8/2010	12/8/2010
49	476	7/6/2010	7/6/2010
50	477	8/7/2010	8/7/2010

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1	CLAIM	ADMITTED	DISCHARGED
2	478	9/23/2010	9/23/2010
3	479	10/9/2010	10/9/2010
4	480	10/10/2010	10/10/2010
5	481	10/26/2010	10/26/2010
6	482	11/3/2010	11/3/2010
7	483	2/5/2011	2/5/2011
8	484	7/11/2010	7/11/2010
9	485	7/23/2010	7/23/2010
10	486	8/1/2010	8/1/2010
11	487	8/22/2010	8/22/2010
12	488	9/5/2010	9/5/2010
13	489	9/18/2010	9/18/2010
14	490	10/18/2010	10/18/2010
15	491	11/25/2010	11/25/2010
16	492	11/28/2010	11/28/2010
17	493	12/30/2010	12/30/2010
18	494	2/4/2011	2/4/2011
19	495	2/12/2011	2/12/2011
20	496	3/10/2011	3/10/2011
21	497	3/14/2011	3/14/2011
22	498	2/14/2011	2/14/2011
23	499	2/16/2011	2/16/2011
24	500	2/23/2011	2/23/2011
25	501	12/1/2010	12/1/2010
26	502	3/8/2011	3/8/2011
27	503	9/8/2010	9/8/2010
28	504	7/7/2010	7/7/2010
29	505	1/14/2011	1/14/2011
30	506	7/2/2010	7/2/2010
31	507	7/8/2010	7/8/2010
32	508	7/22/2010	7/22/2010
33	509	7/23/2010	7/23/2010
34	510	7/26/2010	7/26/2010
35	511	7/30/2010	7/30/2010
36	512	8/4/2010	8/4/2010
37	513	8/18/2010	8/18/2010
38	514	9/5/2010	9/5/2010
39	515	11/27/2010	11/27/2010
40	516	1/26/2011	1/26/2011
41	517	1/31/2011	1/31/2011
42	518	7/26/2010	7/26/2010
43	519	10/27/2010	10/27/2010
44	520	10/8/2010	10/8/2010
45	521	11/14/2010	11/14/2010
46	522	11/23/2010	11/23/2010
47	523	10/1/2010	10/1/2010
48	524	11/12/2010	11/12/2010
49	525	12/3/2010	12/3/2010
50	526	10/5/2010	10/5/2010
51	527	11/30/2010	11/30/2010

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1	CLAIM	ADMITTED	DISCHARGED
2	528	7/15/2010	7/15/2010
3	529	3/23/2011	3/23/2011
4	530	11/10/2010	11/10/2010
5	531	9/18/2010	9/18/2010
6	532	11/14/2010	11/14/2010
7	533	12/29/2010	12/29/2010
8	534	12/30/2010	12/30/2010
9	535	1/10/2011	1/10/2011
10	536	1/28/2011	1/28/2011
11	537	11/30/2010	11/30/2010
12	538	1/3/2011	1/3/2011
13	539	1/18/2011	1/18/2011
14	540	7/8/2010	7/8/2010
15	541	9/3/2010	9/3/2010
16	542	1/10/2011	1/10/2011
17	543	1/16/2011	1/16/2011
18	544	10/28/2010	10/28/2010
19	545	2/16/2011	2/16/2011
20	546	7/28/2010	7/28/2010
21	547	3/3/2011	3/3/2011
22	548	9/8/2010	9/8/2010
23	549	12/18/2010	12/18/2010
24	550	9/17/2010	9/17/2010
25	551	8/31/2010	8/31/2010
26	552	9/7/2010	9/7/2010
27	553	12/20/2010	12/20/2010
28	554	12/26/2010	12/26/2010
	555	1/15/2011	1/15/2011
	556	2/6/2011	2/6/2011
	557	3/2/2011	3/2/2011
	558	8/13/2010	8/13/2010
	559	9/19/2010	9/19/2010
	560	9/2/2010	9/2/2010
	561	7/28/2010	7/28/2010
	562	3/6/2011	3/6/2011
	563	7/22/2010	7/22/2010
	564	8/8/2010	8/8/2010
	565	8/29/2010	8/29/2010
	566	12/12/2010	12/12/2010
	567	7/28/2010	7/28/2010
	568	8/17/2010	8/17/2010
	569	9/3/2010	9/3/2010
	570	11/8/2010	11/8/2010
	571	1/12/2011	1/12/2011
	572	1/31/2011	1/31/2011
	573	2/22/2011	2/22/2011
	574	8/9/2010	8/9/2010
	575	9/10/2010	9/10/2010
	576	2/1/2011	2/1/2011
	577	3/11/2011	3/11/2011

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CLAIM	ADMITTED	DISCHARGED
578	8/9/2010	8/9/2010
579	8/31/2010	8/31/2010

86. Although a small number of the claims in the preceding paragraph may have been properly billed as inpatient under limited circumstances (e.g., if the patient expired or was transferred to another facility), the vast majority of the identified claims were billed knowingly and improperly as inpatient when the patient was discharged from the hospital on the same calendar day that he or she entered it.

9 Specific False Claims — One-Day Stays

10 87. Ms. Guardiola alleges that defendants also routinely submitted to Medicare false
 11 claims for inpatient admissions for elective surgical procedures where the patient's length of stay
 12 in the hospital was one day or less ("One-Day Stays"). A length of stay of one day or less means
 13 that the patient's time in the hospital spanned no more than one midnight. An elective outpatient
 14 surgical procedure is one performed when the patient's condition is neither urgent nor emergent
 15 and permitted adequate time to schedule the availability of a suitable accommodation. (A One-
 16 Day Stay might also be characterized as a Zero-Day Stay if a patient's time in the hospital was
 17 less than 24 hours.)

19 88. The following elective surgical Medicare claims, for which relator will, under an
 20 appropriate protective order, provide additional patient information, are illustrative of the types of
 21 One-Day Stays for which Renown knowingly and improperly billed government-funded health
 22 insurance on an inpatient basis when the claims should have been billed on a less costly
 23 outpatient or outpatient observation basis:

CLAIM	ADMITTED	DISCHARGED
1	03/10/09	03/11/09
2	04/08/09	04/09/09
3	03/22/09	03/22/09
4	03/27/09	03/28/09

1	CLAIM	ADMITTED	DISCHARGED
2	5	04/15/09	04/16/09
3	6	06/08/09	06/08/09
4	7	01/29/10	01/30/10
5	8	08/04/10	08/05/10
6	9	08/21/10	08/22/10
7	10	09/17/10	09/18/10
8	11	03/01/11	03/02/11
9	12	09/17/10	09/18/10
10	13	03/04/11	03/05/11
11	14	03/14/11	03/15/11
12	15	12/08/10	12/09/10
13	16	12/21/10	12/22/10
14	17	01/04/11	01/05/11
15	18	01/11/11	01/12/11
16	19	10/24/08	10/25/08
17	20	02/21/09	02/21/09
18	21	05/11/09	05/12/09
19	22	04/25/09	04/25/09
20	23	09/17/10	09/18/10
21	24	07/15/10	07/16/10
22	25	07/08/10	07/09/10
23	26	09/22/10	09/23/10
24	27	09/07/10	09/08/10
25	28	11/30/10	12/01/10
26	29	12/03/10	12/04/10
27	30	12/23/10	12/24/10
28	31	12/08/10	12/09/10
29	32	12/08/10	12/09/10
30	33	12/14/10	12/15/10
31	34	04/12/09	04/13/09
32	35	12/15/10	12/16/10
33	36	12/15/10	12/16/10
34	37	03/17/11	03/18/11
35	38	03/29/11	03/30/11
36	39	03/30/11	03/31/11
37	40	03/28/11	03/29/11
38	41	12/26/08	12/27/08
39	42	04/30/09	05/01/09
40	43	12/15/10	12/16/10
41	44	01/27/11	01/28/11
42	45	09/08/10	09/09/10
43	46	08/02/10	08/03/10
44	47	03/02/11	03/03/11

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1	CLAIM	ADMITTED	DISCHARGED
2	48	03/30/11	03/31/11
3	49	06/30/08	07/01/08
4	50	09/18/08	09/19/08
5	51	10/07/10	10/08/10
6	52	12/03/08	12/04/08
	53	03/25/09	03/26/09
	54	10/20/10	10/21/10
	55	08/04/10	08/05/10

7 89. Although relator's allegations are not limited by specialty, each claim identified in
 8 the preceding paragraph (except #34) involves an elective surgical procedure within the
 9 specialties of Thyroid, OB/GYN, Cardiology or "Spine."

10 90. Although the reasons differ for individual patients, there are common themes
 11 reflected across the patient files. Often the procedures involved are not listed on Medicare's
 12 Inpatient Only List and, as a result, must be billed on an outpatient basis absent pre-admission
 13 documentation identifying a comorbidity supporting the need for inpatient treatment or post-
 14 procedure documentation of a complication requiring inpatient care. Many are missing doctor's
 15 admission orders indicating that inpatient status is medically necessary. Most patients were
 16 discharged within 24 hours and doctors' orders prescribed discharge after a period in recovery.
 17 All lack any medical documentation of pre-existing conditions or post-procedure complications
 18 that would justify inpatient admission. In each case, there is no evidence that during or after
 19 performance of the procedure the patient developed a condition that would warrant inpatient
 20 treatment. In each case, the government paid an inflated amount as a direct result of Renown's
 21 fraud.

22 91. Patient #34 entered Renown with a medical condition through the emergency
 23 room. Despite a physician's order placing the patient in outpatient observation status, Renown
 24 billed the claim as inpatient. As a direct result of Renown's wrongdoing, the government paid an
 25

1 inflated amount for this patient's care.

2 **Renown Management Directed that Claims Be Billed Improperly**

3 92. The defendants' management at individual hospitals, as well as the corporate level,
 4 are aware of these fraudulent practices and encouraged and facilitated the continuing fraud
 5 against government-funded health insurance programs.
 6

7 93. The cultural and systemic resistance Ms. Guardiola faced in trying to correct
 8 problems at Renown were caused by directives from corporate and senior hospital management.

9 94. During two meetings in which Ms. Guardiola participated during the 4th quarter of
 10 2011, physicians identified Renown management as the source of instructions to always bill
 11 certain types of procedures as inpatient. The meetings, which were attended by Renown CEO
 12 Greg Boyer, COO Kris Gaw and several other corporate executives, were held with cardiologists
 13 to explain claim denials being imposed on Renown as a result of audits performed by Medicare's
 14 Recovery Audit Contractors (RACs). During the meetings, several physicians chaffed at the
 15 notion that they were improperly categorizing patients as inpatient. Drs. Francis Kelley and
 16 Thomas Nylk objected, saying that the inpatient designations were used at the explicit direction of
 17 Renown.
 18

19 95. COO Gaw and CEO Boyer reacted to the comments by admitting that had
 20 occurred in the past, but stating that a new procedure needed to be used going forward.
 21

22 96. In a separate meeting with Drs. John Erickson and Larry Klaich from OB/GYN
 23 Associates to discuss billing of da Vinci procedures in OB/GYN cases, Ms. Guardiola was told
 24 that they had been directed by Linda Ferris, Renown's former VP of Oncology, to treat all
 25 procedures performed using the da Vinci robotic system as inpatient.

26 97. The physicians' statements were consistent with prior emails that Ms. Guardiola
 27 had seen. For instance, in April 2011, Dr. Martin Naughton's office contacted Jessica Marquis, a
 28

1 Patient Access Lead at Regional, to complain about a patient's da Vinci hysterectomy not being
 2 approved for inpatient admission. When informed that the procedures "are outpatient codes per
 3 Medicare's inpatient only list," the physician's representative told Ms. Marquis that "Renown and
 4 her [the doctor's] management team had a meeting and said that all Da Vinci hysterectomy
 5 procedures need to be inpatient."

7 98. The high dollar value of an inpatient admission gives Renown ample motive to
 8 encourage physicians to increase inpatient admissions. And physicians have ample motive to be
 9 generous in categorizing patients as inpatients. This is because Renown engages in a financial
 10 strategy known as "service line management" by which the profitability of each medical specialty
 11 is evaluated separately and the referral volume and revenue performance of individual physicians
 12 is tracked meticulously.

14 99. As a result, Renown and physicians are under pressure to generate additional
 15 revenues. In the Cardiology area, for instance, the defendants created the Renown Institute for
 16 Heart & Vascular Health and incurred significant investment in expensive cutting-edge
 17 technology. During 2011, Renown constructed four new cardiac catheter suites at a cost of
 18 between \$5-10 million.

19 100. Moreover, Renown was also under pressure to generate revenues in its daVinci
 20 robotics practices. Dr. Lim, a physician specializing in OB/GYN Oncology and Renown's
 21 medical director for daVinci robotics, successfully pressed for Renown to purchase two daVinci
 22 robotic systems at a cost of almost \$4 million during 2009 and 2010. Such expenditures must be
 23 paid for by increased patient treatment and billing.

25 101. By the end of 2011, Ms. Guardiola realized that defendants' leadership would not
 26 implement corrections to address the billing fraud. Recognizing that her effectiveness was
 27 undermined and discouraged by the ongoing fraud, Ms. Guardiola resigned her position in

1 January 2012.

2 102. The Renown Health defendants know that when a patient does not meet inpatient
3 level of care criteria but is admitted for a one-day stay, payment may not be sought under the
4 inpatient MS-DRG system (Medicare Part A) and must be submitted as an outpatient claim
5 (Medicare Part B). Renown Health also recognizes that if a patient's treatment is erroneously
6 billed as an inpatient service, a corrected claim form should be submitted to correct the billing.
7 Renown knowingly submitted false claims for inpatient claims to government-funded health
8 insurance programs and failed to correct inaccurate bills it submitted.

9 103. The Renown Health defendants know the Medicare rules pertaining to billing for
10 outpatient observation services. Defendants knowingly submitted false claims for outpatient
11 observation claims to government-funded health insurance programs and failed to correct
12 inaccurate bills it submitted.

13 104. The Renown Health defendants know that CMS will not pay for services that are
14 not "medically necessary" and appropriate (e.g., 42 U.S.C. § 1320c-5(a)(3), 42 U.S.C.
15 § 1395y(a)(1)(A)), or for services provided that are substantially in excess of patient needs (e.g.,
16 42 U.S.C. § 1320a-7(b)(6), (8)).

17 105. Based on the above and foregoing, the Renown Health defendants engaged in a
18 scheme whereby they knowingly submitted claims for payment to CMS and the U.S. Government
19 falsely representing that the patients were properly billed as inpatient and falsely certifying that
20 inpatient admission was appropriate.

21 106. The Renown Health defendants knowingly submitted false claims to Medicare for
22 inpatient services that should have been billed on an outpatient basis.

23 107. If CMS had known of the falsity of the claims submitted by defendants, it would
24 not have paid or approved those claims.

1 108. By submitting false claims to the Medicare program, the Renown Health
2 defendants falsely certified compliance with Medicare laws (e.g., 42 U.S.C. § 1395y(a)(1)(A)),
3 regulations and program instructions, as set forth in the Medicare Provider Agreement (CMS-
4 855A).

5 109. By submitting false claims to the Medicare program, the Renown Health
6 defendants falsely certified on the Provider Agreement (CMS-855A), the Medicare EDI
7 Enrollment Form, the Medicare UB-04 (CMS-1450) Claim Form, the Medicare 837I Electronic
8 Claim Form, and/or similar documents that the services were rendered and the claims were
9 submitted in compliance with Medicare laws, regulations and program instructions.

10 110. If CMS had known of the falsity of defendants' certification, it would not have
11 paid or approved those claims submitted by defendants in violation of or noncompliance with
12 those certifications.

13 111. The Renown Health defendants knew at the time they submitted the false claims
14 that the services provided under those claims did not comply with Medicare laws, regulations and
15 program instructions and that defendants were not entitled to payment or approval of those claims
16 under Medicare laws, regulations and program instructions.

17 112. The United States, unaware of the defendants' wrongdoing or the falsity of the
18 records, statements or claims made by the defendants, paid claims that would not otherwise have
19 been paid or approved.

20 113. Based on the material falsehoods contained in defendants' false claims for
21 reimbursement to the Medicare system, CMS and the United States Government approved and
22 paid claims that would not otherwise have been paid or approved.

COUNT ONE
False Claims Act
31 U.S.C. § 3729(a)(1)(A)

114. Relator re-alleges and incorporates by reference the allegations contained in Paragraphs 1 through 113 of this complaint.

115. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended.

116. By virtue of the acts described above, the defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval to the United States Government.

117. By virtue of the acts described above, the defendants knowingly falsely certified on the Provider Agreement (CMS-855A), the Medicare EDI Enrollment Form, the Medicare UB-04 (CMS-1450) Claim Form, the Medicare 837I Electronic Claim Form and/or similar documents, that the claims for reimbursement submitted or caused to be submitted were for services provided in compliance with Medicare laws, regulations and program instructions.

118. By virtue of the acts described above, the defendants knowingly concealed the existence of their improper conduct from the United States Government in order to induce payment of false or fraudulent claims.

119. The United States, unaware of the defendants' wrongdoing or the falsity of the records, statements or claims made by the defendants, paid or approved claims that would not otherwise have been paid or approved.

120. If the United States had been aware of the falsity of the claims submitted by defendants, the United States would not have paid or approved the claims.

121. By reason of these payments, the United States has been damaged, and continues to be damaged, in substantial amount.

COUNT TWO
False Claims Act
31 U.S.C. § 3729(a)(1)(B)

122. Relator re-alleges and incorporates by reference the allegations contained in paragraphs 1 through 113 of this complaint.

123. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended.

124. By virtue of the acts described above, the defendants knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid by the United States Government.

125. By virtue of the acts described above, the defendants knowingly falsely certified on the Provider Agreement (CMS-855A), the Medicare EDI Enrollment Form, the Medicare UB-04 (CMS-1450) Claim Form, the Medicare 837I Electronic Claim Form and/or similar documents, that the claims for reimbursement submitted or caused to be submitted were for services provided in compliance with Medicare laws, regulations and program instructions.

126. By virtue of the acts described above, the defendants knowingly concealed the existence of their improper conduct from the United States Government in order to induce payment of their false or fraudulent claims.

127. The United States, unaware of the defendants' wrongdoing or the falsity of the records, statements or claims made by the defendants, paid claims that would not otherwise have been paid or approved.

128. If the United States had been aware of the falsity of the claims submitted by defendants, the United States would not have paid or approved the claims.

129. By reason of these payments, the United States has been damaged, and continues to be damaged, in substantial amount.

COUNT THREE
False Claims Act
31 U.S.C. § 3729(a)(1)(G)

130. Relator re-alleges and incorporates by reference the allegations contained in paragraphs 1 through 113 of this complaint.

131. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended.

132. By virtue of the acts described above, the defendants knowingly concealed an obligation to pay or transmit money to the United States Government.

133. By virtue of the acts described above, the defendants knowingly and improperly avoided or decreased an obligation to pay or transmit money to the United States Government.

134. By virtue of the acts described above, the defendants knowingly concealed the existence of their improper conduct from the United States Government in order to conceal and retain payments received as a result of their violations of the Act.

135. The United States, unaware of the defendants' wrongdoing or the falsity of the records, statements, or claims made by the defendants, paid claims that would not otherwise have been paid or approved.

136. By reason of these payments, the United States has been damaged, and continues to be damaged, in substantial amount.

WHEREFORE, relator requests that judgment be entered in favor of the United States and relator against the defendants, ordering that:

- a. the defendants cease and desist from violating the FCA, 31 U.S.C. § 3729, *et seq.*;
- b. the defendants pay an amount equal to three times the amount of damages that the United States have sustained because of the defendants' actions, plus a civil penalty of not less than \$5,500 and not more than \$11,000 for each violation of the FCA, 31 U.S.C. § 3729;

- c. Relator be awarded the maximum amount allowed pursuant to the FCA, 31 U.S.C. § 3730(d);
- d. Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to the FCA, 31 U.S.C. § 3730(d); and
- f. the United States and relator recover such other relief as the Court deems just and proper.

REQUEST FOR TRIAL BY JURY

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, relator hereby demands a trial by jury.

Respectfully submitted,

/s/ William E. Peterson

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ATTORNEYS FOR *QUI TAM*
RELATOR CECILIA GUARDIOLA

CERTIFICATE OF SERVICE

I, the undersigned, declare under penalty of perjury, that I am over the age of eighteen (18) years, and I am not a party to, nor interested in, this action. On January 6, 2015, I caused to be served a true and correct copy of the foregoing **SECOND AMENDED COMPLAINT** by the method indicated:

- BY FAX: by transmitting via facsimile the document(s) listed above to the fax number(s) set forth below on this date before 5:00 p.m. pursuant to EDCR Rule 7.26(a). A printed transmission record is attached to the file copy of this document(s).
- BY U.S. MAIL: by placing the document(s) listed above in a sealed envelope with postage thereon fully prepaid, in the United States mail at Las Vegas, Nevada addressed as set forth below.
- BY EMAIL: by emailing a PDF of the document(s) listed above to the email addresses of the individual(s) listed below.
- BY OVERNIGHT MAIL: by causing document(s) to be picked up by an overnight delivery service company for delivery to the addressee(s) on the next business day.
- BY PERSONAL DELIVERY: by causing personal delivery by _____, a messenger service with which this firm maintains an account, of the document(s) listed above to the person(s) at the address(es) set forth below.
- BY ELECTRONIC SUBMISSION: submitted to the above-entitled Court for electronic filing and service upon the Court's Service List for the above-referenced case.

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